PREVAILED	Roll Call No. _____
FAILED	Ayes _____
WITHDRAWN	Noes _____
RULED OUT OF ORDER	

HOUSE MOTION ____

MR. SPEAKER:

I move that House Bill 1054 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 27-2-20 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 20. Grievance Procedures for Property and Casualty Insurers

Sec. 1. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a policy of property and casualty insurance. The term includes a third party who has been damaged by an action of an insurer or an insured.

Sec. 3. As used in this chapter, "department" refers to the department of insurance.

Sec. 4. As used in this chapter, "external grievance" means the independent review under IC 27-2-21 of a grievance filed under this chapter.

Sec. 5. As used in this chapter, "grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding an unfair claim settlement practice described in IC 27-4-1-4.5 for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

Sec. 6. As used in this chapter, "grievance procedure" means a written procedure established and maintained by an insurer for filing, investigating, and resolving grievances and appeals.

Sec. 7. As used in this chapter, "insured" means an individual in whose name a policy of property and casualty insurance is issued.

Sec. 8. As used in this chapter, "insurer" means an insurer (as defined in IC 27-1-2-3) that delivers or issues for delivery a policy of property and casualty insurance in Indiana.

Sec. 9. As used in this chapter, "policy of property and casualty insurance" means an insurance policy that provides one (1) or more of the kind of insurance described in Class 2 or Class 3 of IC 27-1-5-1.

Sec. 10. An insurer shall establish and maintain a grievance procedure that complies with the requirements of this chapter for the resolution of grievances initiated by a covered individual.

Sec. 11. The commissioner may examine the grievance procedure of any insurer.

Sec. 12. An insurer shall maintain all grievance records received by the insurer after the most recent examination of the insurer's grievance procedure by the commissioner.

Sec. 13. (a) An insurer shall provide timely, adequate, and appropriate notice to each insured of:

(1) the grievance procedure required under this chapter;

(2) the external grievance procedure required under IC 27-2-21;

(3) information on how to file:

(A) a grievance under this chapter; and

(B) a request for an external grievance review under IC 27-2-21; and

(4) a toll free telephone number through which a covered individual may contact the insurer at no cost to the covered individual to obtain information and to file grievances.

(b) An insurer shall prominently display on all notices to covered individuals the toll free telephone number and the address at which a grievance or request for external grievance review may be filed.

Sec. 14. (a) A covered individual may file a grievance orally or in writing.

(b) An insurer shall make available to covered individuals a toll free telephone number through which a grievance may be filed. The toll free telephone number must:

(1) be staffed by a qualified representative of the insurer;

(2) be available for at least forty (40) hours per week during normal business hours; and

(3) accept grievances in the languages of the major population groups served by the insurer.

(c) A grievance is considered to be filed on the first date it is received, either by telephone or in writing.

Sec. 15. (a) An insurer shall establish procedures to assist covered individuals in filing grievances.

(b) A covered individual may designate a representative to file a grievance for the covered individual and to represent the covered individual in a grievance under this chapter.

Sec. 16. (a) An insurer shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following:

(1) An oral or a written acknowledgment of the grievance to the covered individual within five (5) business days after receipt of the grievance.

(2) Documentation of the substance of the grievance and any actions taken.

(3) An investigation of the substance of the grievance.

(4) Notification to the covered individual of the disposition of the grievance and the right to appeal.

(5) Standards for timeliness in:

(A) responding to grievances; and

(B) providing notice to covered individuals of:

(i) the disposition of the grievance; and

(ii) the right to appeal.

(b) An insurer shall appoint at least one (1) individual to resolve a grievance.

(c) A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the grievance is filed. If an insurer is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the insurer's control, the insurer shall:

(1) before the twentieth business day, notify the covered individual in writing of the reason for the delay; and

(2) issue a written decision regarding the grievance within an additional ten (10) business days.

(d) An insurer shall notify a covered individual in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the covered individual's right to appeal the decision.

(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Sec. 17. (a) An insurer shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(1) Written or oral acknowledgment of the appeal not more than five (5) business days after the appeal is filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal.

(4) Notification to the covered individual:

(A) of the disposition of an appeal; and

(B) that the covered individual may have the right to further remedies allowed by law.

(5) Standards for timeliness in:

(A) responding to an appeal; and

(B) providing notice to covered individuals of:

(i) the disposition of an appeal; and

(ii) the right to initiate an external grievance review under IC 27-2-21.

(b) An appeal of a grievance decision must be resolved not later than forty-five (45) days after the appeal is filed.

(c) An insurer shall notify a covered individual in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the covered individual's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-2-21.

(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

Sec. 18. (a) An insurer shall each year file with the commissioner a description of the grievance procedure of the insurer established under this chapter, including:

(1) the total number of grievances handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those grievances; and

(3) a summary of the final disposition of those grievances.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The

commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

Sec. 19. The department may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 2. IC 27-2-21 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 21. External Review of Grievances for Property and Casualty Insurers

Sec. 1. As used in this chapter, "appeal" means the procedure described in IC 27-2-20-17.

Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

Sec. 3. As used in this chapter, "covered individual" has the meaning set forth in IC 27-2-20-2.

Sec. 4. As used in this chapter, "department" refers to the department of insurance.

Sec. 5. As used in this chapter, "external grievance" means the independent review under this chapter of a grievance filed under IC 27-2-20.

Sec. 6. As used in this chapter, "grievance" has the meaning set forth in IC 27-2-20-5.

Sec. 7. As used in this chapter, "grievance procedure" has the meaning set forth in IC 27-2-20-6.

Sec. 8. As used in this chapter, "insured" has the meaning set forth in IC 27-2-20-7.

Sec.9. As used in this chapter, "insurer" has the meaning set forth in IC 27-2-20-8.

Sec. 10. As used in this chapter, "policy of property and casualty insurance" has the meaning set forth in IC 27-2-20-9.

Sec. 11. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding an adverse determination made by an insurer or an agent of an insurer regarding coverage under a policy of property and casualty insurance.

Sec. 12. (a) An external grievance procedure established under section 11 of this chapter must:

(1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's appeal resolution under IC 27-2-20-17 not more than forty-five (45) days after

the covered individual is notified of the resolution; and

(2) provide for a external grievance review.

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 18 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a review professional who is knowledgeable about the subject matter of the grievance for resolution of an external grievance.

(d) The independent review organization and the review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The provider of the service that is the subject of the grievance.

(4) The facility at which the service would be provided.

However, the review professional may have an affiliation under which the review professional provides services to covered individuals of the insurer, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual may be required to pay not more than twenty-five dollars ($25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the insurer.

Sec. 13. (a) A covered individual who files an external grievance under this chapter:

(1) shall not be subject to retaliation for exercising the covered individual's right to an external grievance under this chapter;

(2) shall be permitted to use the assistance of other individuals, including service providers, attorneys, friends, and family members throughout the review process;

(3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and

(4) shall cooperate with the independent review organization by:

(A) providing any requested claim related information; or

(B) authorizing the release of necessary claim related information.

(b) An insurer shall cooperate with an independent review organization selected under section 12(b) of this chapter by promptly providing any information requested by the independent review organization.

Sec. 14. (a) An independent review organization shall, not more than fifteen (15) business days after the appeal is filed, make a determination to uphold or reverse the insurer's appeal resolution under IC 27-2-20-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the service provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization shall apply:

(1) standards of decision making that are based on objective evidence; and

(2) the terms of the covered individual's policy of property and casualty insurance.

(c) The independent review organization shall notify the insurer and the covered individual of the determination made under this section within seventy-two (72) hours after making the determination.

Sec. 15. A determination made under section 14 of this chapter is binding on the insurer.

Sec. 16. (a) If, at any time during an external review performed under this chapter, the covered individual submits information to the insurer that is relevant to the insurer's resolution of the covered individual's appeal of a grievance decision under IC 27-2-20-17 and that was not considered by the insurer under IC 27-2-20:

(1) the insurer may reconsider the resolution under IC 27-2-20-17; and

(2) if the insurer chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration under subsection (b) is completed.

(b) An insurer reconsidering the resolution of an appeal of a grievance decision due to the submission of information under subsection (a) shall reconsider the resolution under IC 27-2-20-17 based on the information and notify the covered individual of the insurer's decision within fifteen (15) days after the information is submitted.

(c) If the decision reached under subsection (b) is adverse to the

covered individual, the covered individual may request that the independent review organization resume the external review under this chapter.

(d) If an insurer to which information is submitted under subsection (a) chooses not to reconsider the insurer's resolution under IC 27-2-20-17, the insurer shall forward the submitted information to the independent review organization not more than two (2) business days after the insurer's receipt of the information.

Sec. 17. This chapter does not add to or otherwise change the terms of coverage included in a policy of property and casualty insurance.

Sec. 18. (a) The department shall establish and maintain a process for annual certification of independent review organizations.

(b) The department shall certify a number of independent review organizations determined by the department to be sufficient to fulfill the purposes of this chapter.

(c) An independent review organization must meet the following minimum requirements for certification by the department:

(1) Review professionals assigned by the independent review organization to perform external grievance reviews under this chapter must be knowledgeable about the subject matter of the grievance.

(2) The independent review organization must have a quality assurance mechanism to ensure:

(A) the timeliness and quality of reviews;

(B) the qualifications and independence of review professionals;

(C) the confidentiality of claim related records and other review materials; and

(D) the satisfaction of covered individuals with the procedures utilized by the independent review organization, including the use of covered individual satisfaction surveys.

(3) The independent review organization must file with the department the following information on or before March 1 of each year:

(A) The number and percentage of determinations made in favor of covered individuals.

(B) The number and percentage of determinations made in favor of insurers.

(C) The average time to process a determination.

(D) Any other information required by the department.

The information required under this subdivision must be specified for each insurer for which the independent review organization performed reviews during the reporting year.

(4) Any additional requirements established by the

department.

(d) The department may not certify an independent review organization that is one (1) of the following:

(1) A professional or trade association of service providers or a subsidiary or an affiliate of a professional or trade association of service providers.

(2) An insurer or a subsidiary or an affiliate of an insurer.

(e) The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.

(f) The department shall make available to insurers a list of all certified independent review organizations.

(g) The department shall make the information provided to the department under subsection (c)(3) available to the public in a format that does not identify individual covered individuals.

Sec. 19. Except as provided in section 18(g) of this chapter, documents and other information created or received by the independent review organization or the review professional in connection with an external grievance review under this chapter:

(1) are not public records;

(2) may not be disclosed under IC 5-14-3; and

(3) must be treated in accordance with confidentiality requirements of state and federal law.

Sec. 20. (a) An insurer shall each year file with the commissioner a description of the grievance procedure established by the insurer under this chapter, including:

(1) the total number of external grievances handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those grievances; and

(3) a summary of the final disposition of those grievances;

for each independent review organization used by the insurer during the reporting year.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports that are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

Sec. 21. (a) An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.

(b) The work product or determination, or both, of an independent review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy a party's burden of proof or persuasion concerning any material issue of fact or law.

Sec. 22. The department may adopt rules under IC 4-22-2 to implement this chapter.".

Page 1, line 2, after "18." insert "**(a)**".

Page 1, after line 8, begin a new paragraph and insert:

"**(b) A cause of action described in subsection (a) may not be commenced until the internal and external grievance procedures established under IC 27-2-20, IC 27-2-21, IC 27-8-28, and IC 27-8-29 have been exhausted.**

SECTION 4. IC 27-8-17-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 12. (a) A utilization review agent shall make available ~~upon request~~ **to an enrollee at the time an adverse utilization review determination is made, and to a provider of record upon request:**

(1) a written description of the appeals procedure by which an enrollee or a provider of record may ~~obtain a review of a~~ **appeal the** utilization review determination by the utilization review agent; **and**

(2) in the case of an enrollee covered under an accident and sickness policy or a health maintenance organization contract described in subsection (d), notice that the enrollee has the right to appeal the utilization review determination under IC 27-8-28 or IC 27-13-10 and the toll free telephone number that the enrollee may call to request a review of the determination or obtain further information about the right to appeal.

(b) The appeals procedure provided by a utilization review agent must meet the following requirements:

(1) On appeal, the determination not to certify an admission, a service, or a procedure as necessary or appropriate must be made by a health care provider licensed in the same discipline as the provider of record.

(2) The determination of the appeal of a utilization review determination not to certify an admission, service, or procedure must be completed within thirty (30) days after:

(A) the appeal is filed; and

(B) all information necessary to complete the appeal is received.

(c) A utilization review agent shall provide an expedited appeals process for emergency or life threatening situations. The determination of an expedited appeal under the process required by this subsection

shall be made by a physician and completed within forty-eight (48) hours after:

(1) the appeal is initiated; and

(2) all information necessary to complete the appeal is received by the utilization review agent.

(d) If an enrollee is covered under an accident and sickness insurance policy (as defined in IC 27-8-28-1) or a contract issued by a health maintenance organization (as defined in IC 27-13-1-19), the enrollee's exclusive right to appeal a utilization review determination is provided under IC 27-8-28 or IC 27-13-10, respectively.

(e) A utilization review agent shall make available upon request a written description of the appeals procedure that an enrollee or provider of record may use to obtain a review of a utilization review determination by the utilization review agent.

SECTION 5. IC 27-8-28 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 28. Internal Grievance Procedures

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the kinds of insurance described in Class 1(b) and Class 2(a) of IC 27-1-5-1.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

Sec. 3. As used in this chapter, "covered individual" means an individual who is covered under an accident and sickness insurance policy. The term includes a third party who has been damaged by an action of an insurer.

Sec. 4. As used in this chapter, "department" refers to the department of insurance.

Sec. 5. As used in this chapter, "external grievance" means the

independent review under IC 27-8-29 of a grievance filed under this chapter.

Sec. 6. As used in this chapter, "grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding:

(1) a determination that a service or proposed service is not appropriate or medically necessary;

(2) a determination that a service or proposed service is experimental or investigational;

(3) the availability of participating providers;

(4) the handling or payment of claims for health care services;

(5) matters pertaining to the contractual relationship between:

(A) a covered individual and an insurer; or

(B) a group policyholder and an insurer; or

(6) an unfair claim settlement practice described in IC 27-4-1-4.5;

and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

Sec. 7. As used in this chapter, "grievance procedure" means a written procedure established and maintained by an insurer for filing, investigating, and resolving grievances and appeals.

Sec. 8. As used in this chapter, "insured" means:

(1) an individual whose employment status or other status except family dependency is the basis for coverage under a group accident and sickness insurance policy; or

(2) in the case of an individual accident and sickness insurance policy, the individual in whose name the policy is issued.

Sec. 9. As used in this chapter, "insurer" means any person who delivers or issues for delivery an accident and sickness insurance policy or certificate in Indiana.

Sec. 10. An insurer shall establish and maintain a grievance procedure that complies with the requirements of this chapter for the resolution of grievances initiated by a covered individual.

Sec. 11. The commissioner may examine the grievance procedure of any insurer.

Sec. 12. An insurer shall maintain all grievance records received by the insurer after the most recent examination of the insurer's grievance procedure by the commissioner.

Sec. 13. (a) An insurer shall provide timely, adequate, and appropriate notice to each insured of:

(1) the grievance procedure required under this chapter;

(2) the external grievance procedure required under IC 27-8-29;

(3) information on how to file:

(A) a grievance under this chapter; and

(B) a request for an external grievance review under IC 27-8-29; and

(4) a toll free telephone number through which a covered individual may contact the insurer at no cost to the covered individual to obtain information and to file grievances.

(b) An insurer shall prominently display on all notices to covered individuals the toll free telephone number and the address at which a grievance or request for external grievance review may be filed.

Sec. 14. (a) A covered individual may file a grievance orally or in writing.

(b) An insurer shall make available to covered individuals a toll free telephone number through which a grievance may be filed. The toll free telephone number must:

(1) be staffed by a qualified representative of the insurer;

(2) be available for at least forty (40) hours per week during normal business hours; and

(3) accept grievances in the languages of the major population groups served by the insurer.

(c) A grievance is considered to be filed on the first date it is received, either by telephone or in writing.

Sec. 15. (a) An insurer shall establish procedures to assist covered individuals in filing grievances.

(b) A covered individual may designate a representative to file a grievance for the covered individual and to represent the covered individual in a grievance under this chapter.

Sec. 16. (a) An insurer shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following:

(1) An acknowledgment of the grievance, oral or in writing, to the covered individual within five (5) business days after receipt of the grievance.

(2) Documentation of the substance of the grievance and any actions taken.

(3) An investigation of the substance of the grievance, including any aspects involving clinical care.

(4) Notification to the covered individual of the disposition of the grievance and the right to appeal.

(5) Standards for timeliness in:

(A) responding to grievances; and

(B) providing notice to covered individuals of:

(i) the disposition of the grievance; and

(ii) the right to appeal;

that accommodate the clinical urgency of the situation.

(b) An insurer shall appoint at least one (1) individual to resolve a grievance.

(c) A grievance must be resolved as expeditiously as possible,

but not more than twenty (20) business days after the grievance is filed. If an insurer is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the insurer's control, the insurer shall:

(1) before the twentieth business day, notify the covered individual in writing of the reason for the delay; and

(2) issue a written decision regarding the grievance within an additional ten (10) business days.

(d) An insurer shall notify a covered individual in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the covered individual's right to appeal the decision.

(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Sec. 17. (a) An insurer shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(1) Written or oral acknowledgment of the appeal not more than five (5) business days after the appeal is filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(4) Notification to the covered individual:

(A) of the disposition of an appeal; and

(B) that the covered individual may have the right to further remedies allowed by law.

(5) Standards for timeliness in:

(A) responding to an appeal; and

(B) providing notice to covered individuals of:

(i) the disposition of an appeal; and

(ii) the right to initiate an external grievance review under IC 27-8-29;

that accommodate the clinical urgency of the situation.

(b) In the case of an appeal of a grievance decision described in section 6(1) or 6(2) of this chapter, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel must include one (1) or more individuals who:

(1) have knowledge in the medical condition, procedure, or treatment at issue;

(2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and

(4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved:

(1) as expeditiously as possible, reflecting the clinical urgency of the situation; and

(2) in any case, not later than forty-five (45) days after the appeal is filed.

(d) An insurer shall allow a covered individual the opportunity to:

(1) appear in person before; or

(2) if unable to appear in person, otherwise appropriately communicate with;

the panel appointed under subsection (b).

(e) An insurer shall notify a covered individual in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the covered individual's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-8-29.

(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

Sec. 18. An insurer may not take action against a provider solely on the basis that the provider represents a covered individual in a grievance filed under this chapter.

Sec. 19. (a) An insurer shall each year file with the commissioner a description of the grievance procedure of the insurer established under this chapter, including:

(1) the total number of grievances handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those grievances; and

(3) a summary of the final disposition of those grievances.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

Sec. 20. The department may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 6. IC 27-8-29 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 29. External Review of Grievances

Sec. 1. As used in this chapter, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-28-1.

Sec. 2. As used in this chapter, "appeal" means the procedure described in IC 27-8-28-17.

Sec. 3. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

Sec. 4. As used in this chapter, "covered individual" has the meaning set forth in IC 27-8-28-3.

Sec. 5. As used in this chapter, "department" refers to the department of insurance.

Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a grievance filed under IC 27-8-28.

Sec. 7. As used in this chapter, "grievance" has the meaning set forth in IC 27-8-28-6.

Sec. 8. As used in this chapter, "grievance procedure" has the meaning set forth in IC 27-8-28-7.

Sec. 9. As used in this chapter, "health care provider" means a person:

(1) that provides physician services (as defined in IC 12-15-11-1(a)); or

(2) who is licensed under IC 25-33.

Sec. 10. As used in this chapter, "insured" has the meaning set forth in IC 27-8-28-8.

Sec. 11. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-28-9.

Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

(1) an adverse determination of appropriateness;

(2) an adverse determination of medical necessity; or

(3) a determination that a proposed service is experimental or investigational;

made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's appeal resolution under IC 27-8-28-17 not more than forty-five (45) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug,

device, procedure, or other therapy that is proposed for use by the treating health care provider.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual may be required to pay not more than twenty-five dollars ($25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the insurer.

Sec. 14. (a) A covered individual who files an external grievance under this chapter:

(1) shall not be subject to retaliation for exercising the covered individual's right to an external grievance under this chapter;

(2) shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;

(3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and

(4) shall cooperate with the independent review organization by:

(A) providing any requested medical information; or

(B) authorizing the release of necessary medical information.

(b) An insurer shall cooperate with an independent review organization selected under section 13(b) of this chapter by promptly providing any information requested by the independent review organization.

Sec. 15. (a) An independent review organization shall:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within three (3) business days after the external grievance is filed; or

(2) for a standard appeal filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the

independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and

(2) the terms of the covered individual's accident and sickness insurance policy.

(c) The independent review organization shall notify the insurer and the covered individual of the determination made under this section:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; and

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

Sec. 16. A determination made under section 15 of this chapter is binding on the insurer.

Sec. 17. (a) If, at any time during an external review performed under this chapter, the covered individual submits information to the insurer that is relevant to the insurer's resolution of the covered individual's appeal of a grievance decision under IC 27-8-28-17 and that was not considered by the insurer under IC 27-8-28:

(1) the insurer may reconsider the resolution under IC 27-8-28-17; and

(2) if the insurer chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration under subsection (b) is completed.

(b) An insurer reconsidering the resolution of an appeal of a grievance decision due to the submission of information under subsection (a) shall reconsider the resolution under IC 27-8-28-17 based on the information and notify the covered individual of the insurer's decision:

(1) within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the covered individual's:

(A) life or health; or

(B) ability to reach and maintain maximum function; or

(2) within fifteen (15) days after the information is submitted, for a reconsideration not described in subdivision (1).

(c) If the decision reached under subsection (b) is adverse to the covered individual, the covered individual may request that the independent review organization resume the external review under this chapter.

(d) If an insurer to which information is submitted under subsection (a) chooses not to reconsider the insurer's resolution under IC 27-8-28-17, the insurer shall forward the submitted

information to the independent review organization not more than two (2) business days after the insurer's receipt of the information.

Sec. 18. This chapter does not add to or otherwise change the terms of coverage included in a policy, certificate, or contract under which a covered individual receives health care benefits under IC 27-8.

Sec. 19. (a) The department shall establish and maintain a process for annual certification of independent review organizations.

(b) The department shall certify a number of independent review organizations determined by the department to be sufficient to fulfill the purposes of this chapter.

(c) An independent review organization must meet the following minimum requirements for certification by the department:

(1) Medical review professionals assigned by the independent review organization to perform external grievance reviews under this chapter:

(A) must be board certified in the specialty in which a covered individual's proposed service would be provided;

(B) must be knowledgeable about a proposed service through actual clinical experience;

(C) must hold an unlimited license to practice in a state of the United States; and

(D) must not have any history of disciplinary actions or sanctions, including:

(i) loss of staff privileges; or

(ii) restriction on participation;

taken or pending by any hospital, government, or regulatory body.

(2) The independent review organization must have a quality assurance mechanism to ensure:

(A) the timeliness and quality of reviews;

(B) the qualifications and independence of medical review professionals;

(C) the confidentiality of medical records and other review materials; and

(D) the satisfaction of covered individuals with the procedures utilized by the independent review organization, including the use of covered individual satisfaction surveys.

(3) The independent review organization must file with the department the following information on or before March 1 of each year:

(A) The number and percentage of determinations made in favor of covered individuals.

(B) The number and percentage of determinations made in favor of insurers.

(C) The average time to process a determination.

(D) Any other information required by the department.

The information required under this subdivision must be specified for each insurer for which the independent review organization performed reviews during the reporting year.

(4) Any additional requirements established by the department.

(d) The department may not certify an independent review organization that is one (1) of the following:

(1) A professional or trade association of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers.

(2) An insurer, a health maintenance organization, or a health plan association, or a subsidiary or an affiliate of an insurer, health maintenance organization, or health plan association.

(e) The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.

(f) The department shall make available to insurers a list of all certified independent review organizations.

(g) The department shall make the information provided to the department under subsection (c)(3) available to the public in a format that does not identify individual covered individuals.

Sec. 20. Except as provided in section 19(g) of this chapter, documents and other information created or received by the independent review organization or the medical review professional in connection with an external grievance review under this chapter:

(1) are not public records;

(2) may not be disclosed under IC 5-14-3; and

(3) must be treated in accordance with confidentiality requirements of state and federal law.

Sec. 21. (a) An insurer shall each year file with the commissioner a description of the grievance procedure established by the insurer under this chapter, including:

(1) the total number of external grievances handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those grievances; and

(3) a summary of the final disposition of those grievances;

for each independent review organization used by the insurer during the reporting year.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

(1) make the information required to be filed under this

section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports that are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

Sec. 22. (a) An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.

(b) The work product or determination, or both, of an independent review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy a party's burden of proof or persuasion concerning any material issue of fact or law.

Sec. 23. If a covered individual has the right to an external review of a grievance under Medicare, the covered individual may not request an external review of the same grievance under this chapter.

Sec. 24. The department may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 7. IC 27-13-10-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 1. A health maintenance organization or limited service health maintenance organization shall establish and maintain a grievance procedure for the resolution of grievances initiated by enrollees, ~~and~~ subscribers, **and third parties who have been damaged by an action** of the organization. The grievance procedure of a health maintenance organization or limited service health maintenance organization must:

(1) be approved by the commissioner; **and**

(2) provide for the filing of a grievance regarding an unfair claim settlement practice described in IC 27-4-1-4.5.

SECTION 8. IC 34-30-2-116.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 116.7. IC 27-2-21-21 and IC 27-8-29-22 (Concerning independent review organizations).**

SECTION 9. [EFFECTIVE JULY 1, 2001] **(a) Notwithstanding IC 27-2-20-18, IC 27-2-21-20, IC 27-8-28-19, and IC 27-8-29-21, all as added by this act, the information required under IC 27-2-20-18, IC 27-2-21-20, IC 27-8-28-19, and IC 27-8-29-21, all as added by**

this act, must be filed beginning March 1, 2003.

(b) This SECTION expires June 30, 2005.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1054 as printed February 22, 2001.)

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Representative Dillon